FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044164

Facility Name: CRESTWOOD CARE CENTRE

Address: 14255 S. CICERO AVE. (Number) CRESTWOOD (City) 60445 (Zip Code)

County: COOK

Telephone Number: (847) 371-0400 **Fax #** (847) 371-5871

IDPA ID Number: 36-3967295

Date of Initial License for Current Owners: 08/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	38,064	1
2		Skilled Pediatric (SNF/PED)			2
3	208	Intermediate (ICF)	208	76,128	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	312	TOTALS	312	114,192	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,677	2,116	7,392	22,185	8
9	SNF/PED					9
10	ICF	53,345	8,910	6,633	68,888	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,022	11,026	14,025	91,073	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 79.75%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 4324

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	466,842	47,864	26,248	540,954		540,954	(1,097)	539,857			1
2	Food Purchase		382,650		382,650		382,650	(1,604)	381,046			2
3	Housekeeping	418,383	61,546	0	479,929		479,929	2,438	482,367			3
4	Laundry	135,161	62,665	6,893	204,719		204,719	932	205,651			4
5	Heat and Other Utilities			166,202	166,202		166,202	0	166,202			5
6	Maintenance	71,264	77,261	99,523	248,048		248,048	(3,079)	244,969			6
7	Other (specify):*			59,182	59,182		59,182	0	59,182			7
8	**TOTAL General Services**	1,091,650	631,986	358,048	2,081,684		2,081,684	(2,410)	2,079,274			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	0	12,000			9
10	Nursing and Medical Records	2,657,191	171,604	186,095	3,014,890		3,014,890	9,274	3,024,164			10
10a	Therapy	222,236		58,658	280,894		280,894	0	280,894			10a
11	Activities	257,808	4,739	4,973	267,520		267,520	(52)	267,468			11
12	Social Services	158,366		9,620	167,986		167,986	0	167,986			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			4,211	4,211		4,211	0	4,211			14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	3,295,601	176,343	275,557	3,747,501		3,747,501	9,222	3,756,723			16
	C. General Administration											
17	Administrative	193,332		893,182	1,086,514		1,086,514	(862,610)	223,904			17
18	Directors Fees			0				0				18
19	Professional Services			354,357	354,357		354,357	18,018	372,375			19
20	Dues, Fees, Subscriptions & Promotions			187,251	187,251		187,251	(134,532)	52,719			20
21	Clerical & General Office Expense	287,555	61,356	92,196	441,107		441,107	155,937	597,044			21
22	Employee Benefits & Payroll Taxes			862,790	862,790		862,790	0	862,790			22
23	Inservice Training & Education			33,209	33,209		33,209	0	33,209			23
24	Travel and Seminar			133	133		133	17,023	17,156			24
25	Other Admin. Staff Transportation			9,487	9,487		9,487	0	9,487			25
26	Insurance-Prop.Liab.Malpractice			24,388	24,388		24,388	164,504	188,892			26
27	Other (specify):*			1,099,550	1,099,550		1,099,550	(1,099,550)				27
28	**TOTAL General Administration**	480,887	61,356	3,556,543	4,098,786		4,098,786	(1,741,210)	2,357,576			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,868,138	869,685	4,190,148	9,927,971		9,927,971	(1,734,398)	8,193,573			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			88,662	88,662		88,662	158,162	246,824			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			160,786	160,786		160,786	239,468	400,254			32
33	Real Estate Taxes			473,902	473,902		473,902	0	473,902			33
34	Rent-Facility & Grounds			1,314,964	1,314,964		1,314,964	(1,292,778)	22,186			34
35	Rent-Equipment & Vehicles			45,348	45,348		45,348	11,241	56,589			35
36	Other (specify):* STORAGE			3,228	3,228		3,228	0	3,228			36
37	TOTAL Ownership			2,086,890	2,086,890		2,086,890	(883,907)	1,202,983			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		161,587	155,705	317,292		317,292	0	317,292			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			171,288	171,288		171,288	0	171,288			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		161,587	326,993	488,580		488,580		488,580			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,868,138	1,031,272	6,604,031	12,503,441	0	12,503,441	(2,618,305)	9,885,136			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(21,624)	30		9
10	Interest and Other Investment Income	(11,238)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,604)	2		13
14	Non-Care Related Interest	(107,401)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(60)	20		17
18	Fines and Penalties	(9,859)	21		18
19	Entertainment	0	20		19
20	Contributions	(5,546)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(3,404)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(1,099,550)	27		24
25	Fund Raising, Advertising and Promotional	(120,267)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(11,178)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(4,664)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,396,395)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	########	G 6 & 6A	34
35	Other- Attach Schedule	(800)	PG 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ ########		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ ########		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name CRESTWOOD CARE CENTRE
ID# 0044164
Report Period Beginning: 01/01/2008
Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	(1,488)
2	**Other Cars for Outpatients**	0	0	**Line 2**	(1,884)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	2,438
4	**Non-Patient Meals**	0	2	**Line 4**	932
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	(3,678)
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(2,410)
9	**Non-Straightline Depreciation**	(21,624)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(11,238)	32	**Line 10**	(4,466)
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	(32)
13	**Sales Tax**	(1,604)	2	**Line 12**	0
14	**Non-Care Related Interest**	(107,401)	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	(60)	20	**Line 16**	(4,452)
18	**Fines and Penalties**	(9,859)	21	**Line 17**	4,452
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(5,546)	20	**Line 19**	(8,406)
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(137,401)
22	**Special Legal Fees & Legal Retainers**	(3,494)	19	**Line 21**	(14,494)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	########	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(120,267)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	(11,178)	20	**Line 27**	(1,099,720)
29	**Non-Paid Workers**	0	0	**Line 28**	(1,250,079)
30	**Donated Goods**	0	0	**Line 29**	(1,256,743)
31	**Amortization Expense**	0	0	**Line 30**	(25,826)
32	PAGE 5 - LINE 35 VACATION ACCRUAL	(1,097)	1	**Line 31**	0
33	PAGE 5 - LINE 35 VACATION ACCRUAL	2,438	3	**Line 32**	(118,420)
34	PAGE 5 - LINE 35 VACATION ACCRUAL	932	4	**Line 33**	0
35	PAGE 5 - LINE 35 VACATION ACCRUAL	1,585	6	**Line 34**	0
36	PAGE 5 - LINE 35 VACATION ACCRUAL	(4,488)	10	**Line 35**	0
37	PAGE 5 - LINE 35 VACATION ACCRUAL	(52)	11	**Line 36**	0
38	PAGE 5 - LINE 35 VACATION ACCRUAL	4,421	17	**Line 37**	(140,283)
39	PAGE 5 - LINE 35 VACATION ACCRUAL	(4,627)	21	**Line 38**	0
40	PAGE 5 - LINE 29 DEFERRED MAINTENANCE	(4,664)	6	**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(1,397,195)

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,097)	0	0	0	0	0	0	0	0	0	0	(1,097)	1
2	Food Purchase	(1,604)	0	0	0	0	0	0	0	0	0	0	(1,604)	2
3	Housekeeping	2,438	0	0	0	0	0	0	0	0	0	0	2,438	3
4	Laundry	932	0	0	0	0	0	0	0	0	0	0	932	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,079)	0	0	0	0	0	0	0	0	0	0	(3,079)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,410)	0	0	0	0	0	0	0	0	0	0	(2,410)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,400)	13,674	0	0	0	0	0	0	0	0	0	9,274	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(52)	0	0	0	0	0	0	0	0	0	0	(52)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	(4,452)	13,674	0	0	0	0	0	0	0	0	0	9,222	16
	C. General Administration													
17	Administrative	4,421	(867,031)	0	0	0	0	0	0	0	0	0	(862,610)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,404)	6,821	14,601	0	0	0	0	0	0	0	0	18,018	19
20	Fees, Subscriptions & Promotions	(137,051)	2,519	0	0	0	0	0	0	0	0	0	(134,532)	20
21	Clerical & General Office Expenses	(14,486)	170,423	0	0	0	0	0	0	0	0	0	155,937	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,023	0	0	0	0	0	0	0	0	0	17,023	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	8,113	156,391	0	0	0	0	0	0	0	0	164,504	26
27	Other (specify):*	########	0	0	0	0	0	0	0	0	0	0	(1,099,550)	27
28	**TOTAL General Administration**	########	(662,132)	170,992	0	0	0	0	0	0	0	0	(1,741,210)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	########	(648,458)	170,992	0	0	0	0	0	0	0	0	(1,734,398)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,624)	14,403	165,383	0	0	0	0	0	0	0	0	158,162	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(118,639)	0	358,107	0	0	0	0	0	0	0	0	239,468	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	22,186	########	0	0	0	0	0	0	0	0	(1,292,778)	34
35	Rent-Equipment & Vehicles	0	11,241	0	0	0	0	0	0	0	0	0	11,241	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(140,263)	47,830	(791,474)	0	0	0	0	0	0	0	0	(883,907)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	########	(600,628)	(620,482)	0	0	0	0	0	0	0	0	(2,618,305)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LT		MANAGEMENT
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
				CRESTWOOD HEIGHTS NURSING CENTRE		
					ROSEMONT, ILL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	10 NURSING	$	FHC ENTERPRISES INC		$ 13,674	$ 13,674	1	13674
2	V	17 ADMINISTRATIVE	892,182	MJC HELLOWS OWNS 22% OF THIS FACILITY		26,353	(865,829)	2	-865831
3	V	19 PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISE		6,821	6,821	3	6821
4	V	20 DUES & SUBSCRIPTIONS		" "		2,519	2,519	4	2519
5	V	21 CLERICAL		" "		170,423	170,423	5	170423
6	V	24 TRAVEL		" "		17,023	17,023	6	17023
7	V	26 INSURANCE		" "		8,113	8,113	7	8113
8	V	28 DEPRECIATION		" "		14,483	14,483	8	14483
9	V	34 RENT		" "		22,186	22,186	9	22186
10	V	25 RENT-EQUIPMENT & VEH		" "		11,241	11,241	10	11241
11	V							11	
12	V							12	
13	V							13	
14	Total		$ 892,182			$ 292,554	$ (600,628)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	RENT	$ 1,314,964	CRESTWOOD HEIGHTS NURSING CENTRE		$	$ ########	15	-1314964
16	V	19	ACCOUNTING FEES		" "		8,700	8,700	16	8700
17	V	19	LEGAL		" "		401	401	17	401
18	V	19	OTHER PROFESSIONAL		" "		5,500	5,500	18	5500
19	V	26	GENERAL INSURANCE		" "		132,364	132,364	19	132364
20	V	26	MORTGAGE INSURANCE		" "		24,027	24,027	20	24027
21	V	30	DEPRECIATION-BLDG, IMP		" "		143,176	143,176	21	143176
22	V	30	DEPRECIATION-EQUIP, FURN		" "		22,207	22,207	22	22207
23	V	32	AMORTIZATION - MTG COST		" "		3,245	3,245	23	3245
24	V	32	MORTGAGE INTEREST		" "		354,862	354,862	24	354862
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 1,314,964			$ 694,482	$ * (620,482)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	22%	SEE ATTACHED	4.23	12.33	SALARY	26,151	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,151		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	480,456	10	$ 72,138	$ 72,138	91,069	$ 13,674	1
2	17	ADMINISTRATIVE	PATIENT DAYS	480,456	10	137,966	137,966	91,069	26,151	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	480,456	10	35,987		91,069	6,821	3
4	20	DUES AND SUBSCRIPTION	PATIENT DAYS	480,456	10	13,291		91,069	2,519	4
5	21	CLERICAL	PATIENT DAYS	480,456	10	742,182	614,621	91,069	140,678	5
6	21	CLERICAL	HOURS	1	1	29,745	29,745	1	29,745	6
7	24	TRAVEL	PATIENT DAYS	480,456	10	89,811		91,069	17,023	7
8	26	INSURANCE	PATIENT DAYS	480,456	10	42,804		91,069	8,113	8
9	30	DEPRECIATION	PATIENT DAYS	480,456	10	75,987		91,069	14,403	9
10	34	RENT	PATIENT DAYS	480,456	10	117,045		91,069	22,186	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	480,456	10	59,305		91,069	11,241	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,416,261	$ 854,470		$ 292,554	25

Print Preview

Print Page 8A

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE		09/97	4,897,900	4,791,865	09/32	7.375	354,862	2
3	GMAC		X	LOAN COST	AMORT-35 YRS		113,573	103,027			3,245	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	DEMAND	VARIOUS	323,671	925,000	DEMAND	PRIME +	44,393	6
7	COUNTRYSIDE CARE	X		WORKING CAPITAL	DEMAND	12/27/00	59,000	59,000	DEMAND	0.095	61	7
8	LOAN FROM PARTNERS	X		WORKING CAPITAL	DEMAND	12/31/99	100,000	100,000	DEMAND	0.0825	8,931	8
9	TOTAL Facility Related						$ 5,494,144	$ 5,978,892			$ 411,492	9
	B. Non-Facility Related*											
10	CRESTWOOD HEIGHTS N	X		WORKING CAPITAL	DEMAND	VARIOUS	1,132,428	1,203,643	DEMAND	VARIOUS	107,401	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 1,132,428	$ 1,203,643			$ 107,401	14
15	TOTALS (line 9+line14)						$ 6,626,572	$ 7,182,535			$ 518,893	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	492,360	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	471,970	2
3. Under or (over) accrual (line 2 minus line 1).	$	(20,390)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	479,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	17,065	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND 2,173 For 19 94 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(2,173)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	473,902	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	460,995	8
	1996	463,218	9
	1997	474,029	10
	1998	481,940	11
	1999	471,970	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

***APPEAL COST ---- IS LEGAL FEES

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960 B. General Construction Type: Exterior STONE Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,000	1972	$ 294,389	1
2	SEWER		1978	41,363	2
3	TOTALS	75,000		$ 335,752	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	312		1974	1974	$ 2,091,708	$ 26,548	35	$ 59,763	$ 33,215	$ 1,608,621	4
5			1980	1980	3,400	0	35	100	100	2,050	5
6	SEC 754 AJ			1992	584,054	18,541	31.5	18,541		157,601	6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE										9
10	REMODELING			1977	34,163		10			34,163	10
11	REMODELING			1980	12,383		10			12,383	11
12	IMPROVEMENTS			1984	38,466	1,756	20		(1,756)	38,466	12
13	IMPROVEMENTS			1985	18,271	934	10		(934)	18,271	13
14	IMPROVEMENTS			1985	1,200	62	20	60	(2)	930	14
15	IMPROVEMENTS			1985	32,506	1,691	15	59	(1,632)	32,506	15
16	IMPROVEMENTS			1986	76,557	3,982	20	3,828	(154)	55,500	16
17	IMPROVEMENTS			1986	16,943	881	10		(881)	16,943	17
18	IMPROVEMENTS			1986	1,559	81	25	62	(19)	899	18
19	IMPROVEMENTS			1987	23,951	761	20	1,198	437	16,164	19
20	IMPROVEMENTS			1987	22,863	726	20	1,143	417	15,431	20
21	IMPROVEMENTS			1988	20,627	1,406	20	1,031	(375)	8,726	21
22	IMPROVEMENTS			1989	35,057	432	31.5	1,113	681	13,179	22
23	IMPROVEMENTS			1990	50,320	1,598	31.5	1,598		16,318	23
24	IMPROVEMENTS			1991	53,090	1,684	31.5	1,684		15,714	24
25	IMPROVEMENTS			1992	53,668	1,704	31.5	1,704		14,516	25
26	IMPROVEMENTS			1992	51,711	3,447	31.5	3,447		28,869	26
27	IMPROVEMENTS			1993	42,479	1,090	15	1,090		7,930	27
28	IMPROVEMENTS			1993	78,601	2,495	39	2,495		19,380	28
29	IMPROVEMENTS			1994	193,211	7,026	27.5	7,026		41,161	29
30	FIRE ALARM SYSTEMS			1995	19,476	708	27.5	708		3,951	30
31	ELEVATOR REHAB			1995	57,000	2,072	27.5	2,072		11,046	31
32	NURSES CALL STATION			1995	6,318	230	27.5	230		1,225	32
33	DINING ROOM AIR CONDITIONING SYSTEM			1995	9,370	341	27.5	341		1,733	33
34					ADJ TO SL	29,097			(29,097)		34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 109,293		$ 109,293	$	$ 2,193,676	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	COOLING TOWER REPLACEMENT			1995	15,650	569	27.5	569		2,890	9
10	HAND RAILS/TILING/ROOF			1996	103,547	3,765	27.5	3,765		17,245	10
11	HAND RAILS			1996	877	32	27.5	32		138	11
12	OUR TOWN			1996	61,800	2,247	27.5	2,247		8,607	12
13	REMODELING EXISTING STRUCTURE/SMOKE DOORS			1997	65,677	2,390	27.5	2,390		8,850	13
14	REMODELING-FLOOR /ENTRYWAYS/WALLS/WINDOWS			1997	406,833	14,794	27.5	14,794		53,944	14
15	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING			1997	44,213	1,607	27.5	1,607		5,671	15
16	WINDOW/OUR TOWN/WALLCOVERING/FLOORS			1997	76,586	2,784	27.5	2,784		9,328	16
17	OUR TOWN			1998	32,000	1,164	27.5	1,164		3,443	17
18	ELECTRICAL WIRING FOR LAUNDRY AREA			1998	4,400	160	27.5	160		473	18
19	REMODELING-FLOOR /ENTRYWAYS/WALLS/WINDOWS			1998	35,000	1,273	27.5	1,273		3,766	19
20	REMODELING-FLOOR /ENTRYWAYS/WALLS/WINDOWS			1998	900	33	27.5	33		97	20
21	REMODELING-FLOOR /ENTRYWAYS/WALLS/WINDOWS			1998	9,604	349	27.5	349		1,033	21
22	AIR CONDITIONING SYSTEM			1998	17,900	651	27.5	651		1,817	22
23	ROOF REPAIRS			1998	2,790	101	27.5	101		282	23
24	BOILER VALVE			1998	5,450	198	27.5	198		404	24
25	WALLCOVERING			1999	2,206	80	27.5	80		227	25
26	METAL DOORS/OAK DOORS AND LOCKSETS			1999	6,267	228	27.5	228		274	26
27	OVERHANG WORK			1999	4,150	151	27.5	151		170	27
28	REMODEL - NURSES STATIONS			2000	25,135	495	27.5	495		495	28
29	A/C COMPRESSOR			2000	27,970	466	27.5	466		466	29
30	ROOF WORK			2000	11,384	121	27.5	121		121	30
31	REMODELING - DIALYSIS ROOM-PLUMBING, ELECTRIC			2000	23,240	176	27.5	176		176	31
32	REMODEL - NURSES STATIONS			2000	10,730	49	27.5	49		49	32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 33,883		$ 33,883	$	$ 119,966	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
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14											14
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 658,607	$ 83,424	$ 64,976	$ (18,448)	3-10 YRS	$ 272,091	37
38	Current Year Purchases	31,314	4,742	1,566	(3,176)	3-10 YRS	1,566	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	1,087,077	36,610	36,610			1,029,356	40
41	TOTALS	$ 1,776,998	$ 124,776	$ 103,152	$ (21,624)		$ 1,303,013	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42			1994	$ 32,522	$	$	$	5	$ 32,522	42
43			1995	8,628	496	496		5	8,628	43
44										44
45										45
46	TOTALS			$ 41,150	$ 496	$ 496	$		$ 41,150	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 268,448	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 246,824	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (21,624)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,657,805	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipm $ 45,348 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 69,956	$		$ 69,956	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				13,891			13,891	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				70,917			70,917	4
5	Physician Care	39-3	visits				941			941	5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					94,572		94,572	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify):	39-2						67,015		67,015	13
14	TOTAL				$		$ 155,705	$ 161,587		$ 317,292	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 16,703	$ 326,408	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 365,152)	2,481,482	2,481,482	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,308	219,510	6
7	Other Prepaid Expenses	19,401	19,401	7
8	Accounts Receivable (owners or related parties)	77,282	2,019,450	8
9	Other(specify): ESCROW DEPOSITS		230,021	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,647,176	$ 5,296,272	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		335,752	13
14	Buildings, at Historical Cost		2,599,266	14
15	Leasehold Improvements, at Historical Cost		1,944,100	15
16	Equipment, at Historical Cost	731,071	1,723,047	16
17	Accumulated Depreciation (book methods)	(529,855)	(3,764,084)	17
18	Deferred Charges	3,089	106,116	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		288,900	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 204,305	$ 3,233,097	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,851,481	$ 8,529,369	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 438,465	$ 549,886	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	984,517	984,517	28
29	Short-Term Notes Payable	2,187,704	984,061	29
30	Accrued Salaries Payable	186,043	186,043	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,688	22,688	31
32	Accrued Real Estate Taxes(Sch.IX-B)		479,400	32
33	Accrued Interest Payable	904	904	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO IDPA	525,358	525,358	36
37	MANAGEMENT FEES	6,647	6,647	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,352,326	$ 3,739,504	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	117,181	117,181	39
40	Mortgage Payable		4,791,865	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 117,181	$ 4,909,046	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,469,507	$ 8,648,550	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,618,026)	$ (119,181)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,851,481	$ 8,529,369	48

***(See instructions.)**

Print Preview

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (335,168)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (335,166)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,282,860)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,282,860)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,618,026)	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,209,343	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,209,343	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,238	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 11,238	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 11,220,581	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 2,081,684	31
32	Health Care	3,747,501	32
33	General Administration	4,098,786	33
	B. Capital Expense		
34	Ownership	2,086,890	34
	C. Ancillary Expense		
35	Special Cost Centers	317,292	35
36	Provider Participation Fee	171,288	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,503,441	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,282,860)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (1,282,860)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	4,554	5,287	160,813	30.42	2
3	Registered Nurses	41,000	46,710	939,772	20.12	3
4	Licensed Practical Nurses	19,016	21,335	372,126	17.44	4
5	Nurse Aides & Orderlies	101,079	112,221	1,027,361	9.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,227	4,933	71,197	14.43	7
8	Rehab/Therapy Aides	9,522	11,054	151,039	13.66	8
9	Activity Director	4,024	4,622	89,027	19.26	9
10	Activity Assistants	14,071	15,839	168,781	10.66	10
11	Social Service Workers	8,040	9,257	158,366	17.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,887	11,943	163,056	13.65	14
15	Cook Helpers/Assistants	35,277	38,573	303,786	7.88	15
16	Dishwashers					16
17	Maintenance Workers	6,044	6,628	71,264	10.75	17
18	Housekeepers	41,202	46,108	418,383	9.07	18
19	Laundry	15,295	16,873	135,161	8.01	19
20	Administrator	1,881	2,286	120,311	52.63	20
21	Assistant Administrator	1,941	2,235	73,021	32.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,593	15,461	287,555	18.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,152	16,197	157,119	9.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	345,805	387,562	$ 4,868,138 *	$ 12.56	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	478	$ 26,248	1-3	35
36	Medical Director	504	12,000	9-3	36
37	Medical Records Consultant	109	4,804	10-3	37
38	Nurse Consultant	1,929	148,033	10-3	38
39	Pharmacist Consultant	1,038	2,700	10-3	39
40	Physical Therapy Consultant	383	24,823	10a-3	40
41	Occupational Therapy Consulta	512	33,835	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	76	4,973	11-3	44
45	Social Service Consultant	148	9,620	12-3	45
46	Other(specify) UTILIZATION	36	3,600	10-3	46
47	PSYCHO-SOCIAL CONSUL	62	4,030	10-3	47
48					48
49	TOTAL (lines 35 - 48)	5,275	$ 274,666		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	318	11,021	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	318	$ 11,021		53

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Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JEANETTE FOX	ADMIN		$ 120,311
DIANE WALKER	ASST. ADMIN.		73,021
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 193,332

B. Administrative - Other

Description	Amount
	$
FIRST HEALTHCARE MANAGEMENT FE	893,182
TOTAL (agree to Schedule V, line 17, col. 3)	$ 893,182
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		354,357
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 354,357

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,110
Unemployment Compensation Insurance	35,612
FICA Taxes	367,356
Employee Health Insurance	307,320
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	21,079
EMPLOYEE BENEFITS-OTHER	45,682
EMPLOYEE PHYSICAL EXAMS	1,631
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 862,790

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	15,875
Health Care Worker Background Chec	1,070
(Indicate # of checks perform 89)	
ADV & PROMO/MARKETING	131,445
DUES & SUBSCRIPTIONS	21,332
LICENSES & PERMITS	11,723
TRUST FEES, CONTRIBUTIONS,etc.	5,606
MGMT CO ALLOCATION	2,519
LESS TRUST FEES, CONTRIB, etc.	(5,606)
Less: Public Relations Expense	( )
Non-allowable advertising	#######
Yellow page advertising	(11,178)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,719

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	133
RELATED PARTY	17,023
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,156

**See instructions.

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Facility Name & ID Num CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1997	$ 2,533	3	$ 422	$ 844	$ 844	$ 423	$	$	$	$	$
2	PAINT/DECORATI	1998	3,207	3		535	1,069	1,069	534				
3	PAINT/DECORATI	2000	7,387	3				1,231	2,462	2,462	1,232		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 13,127		$ 422	$ 1,379	$ 1,913	$ 2,723	$ 2,996	$ 2,462	$ 1,232	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost rep **YES**
If YES, give association name and amo **IL COUNCIL LONG TERM CARE $10692**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this per **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. **6,622** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangeme **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. **171,288**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Secti **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportatio residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and pati **5%**
d. Have vehicle usage logs been maintair **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this co been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost repc **YES**
Attach invoices and a summary of services for all architect and appraisal fees

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Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	26248	
	REPAIRS & MAINTENANCE		0	
			0	26248
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		6893	
			0	6893
5	HEAT & OTHER UTILITIES			
	GAS HEAT		69862	
	ELECTRICITY		76035	
	WATER		20305	
	CABLE TV - LOBBY		0	
			0	166202
6	MAINTENANCE			
	GROUNDS MAINTENANCE		12625	
	PAINTING & DECORATING		7387	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		47434	
	ELEVATOR MAINTENANCE & REPAIR		10180	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4300	
	FIRE SERVICE		7486	
	DEFERRED MAINTENANCE		10111	
			0	
			0	99523
7	OTHER			
	SCAVENGER		15759	
	SECURITY SERVICE		43423	59182
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	12000	12000

LINE		SCHED REF		TOTAL
10	NURSING			
	CONTRACT NURSING	XVIII C53	11021	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		10546	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	4030	
	RESTORATIVE NURSING CONSULTA	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	4804	
	PHARMACY CONSULTANT	XVIII B39	2700	
	UTILIZATION REVIEW FEES	XVIII B46	3600	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	148033	
	CLERGY		900	
	DENTAL SERVICES		461	186095
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	24823	
	OCCUPATIONAL THERAPY CONSUL	XVIII B41	33835	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	58658
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	4973	
			0	4973
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULT	XVIII B45	6240	
	SOCIAL WORKER	XVIII B45	3380	
			0	9620
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		4211	4211
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	893182	893182
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	21253	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	333104	
	ACCOUNT COLLECTION FEES		0	354357
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	120267	
	EMPLOYEE WANT ADS	XIX F	15875	
	CONTRIBUTIONS	VI 20 XIX F	2646	
	DUES & SUBSCRIPTIONS	XIX F	21332	
	LICENSES & PERMITS	XIX F	11923	
	PUBLIC RELATIONS-PATIENT RELA	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	11178	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	60	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2900	
	H/CARE WORKER BACKGROUND CH	XIX F	1070	187251
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		2979	
	EQUIPMENT REPAIR & MAINTENANCE		17620	
	OUTSIDE CLERICAL SERVICES		365	
	PENALTIES	VI 18	9859	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		5085	
	TELEPHONE		55745	
	MESSENGER SERVICE		543	
			0	92196

LINE		SCHED REF		TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	367356	
	UNEMPLOYMENT COMPENSATION	XIX D	35612	
	WORKERS COMPENSATION INSURA	XIX D	84110	
	HOSPITALIZATION INSURANCE	XIX D	307320	
	EMPLOYEE BENEFITS - OTHER	XIX D	45682	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1631	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRII	XIX D	21079	
	CHICAGO HEAD TAX	XIX D	0	862790
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		33209	33209
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	133	
			0	
				133
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		9487	9487
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		24388	24388
27	OTHER			
	BAD DEBTS	VI 24	1099550	
			0	1099550
	GRAND TOTAL COLUMN 3 OTHER			4190148